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ABSTRACT

Fiscal year 1978 activities of the Bureau of Health Planning are presented in this annual report. The report is organized into areawide planning (e.g., health planning was established in 213 geographic regions, including 205 health service areas served by Health Systems Agencies and eight states, territories, and the District of Columbia); statewide planning (e.g., there are now 57 state health planning and development agencies); regulatory activities (e.g., as of October, 1978, 40 states had some kind of certificate of need program and 33 states were participating in the Section 1122 of Social Security Act programs); technical assistance (e.g., during Fiscal Year 1978, approximately 4,500 documents were added to the data base of the National Health Planning Information Center); national guidelines (e.g., the first set of National Guidelines for Health Planning were issued in final form on March 28, 1978); National Council (e.g., the National Council for Health Planning and Development became fully operational in Fiscal Year 1978, holding ten meetings during the year); program policy documents; the statutes (e.g., two health planning bills were introduced in Congress in Fiscal Year 1978); and looking ahead (e.g., in 1979 the Bureau will begin to implement an appropriations review program on a national basis). (JH)

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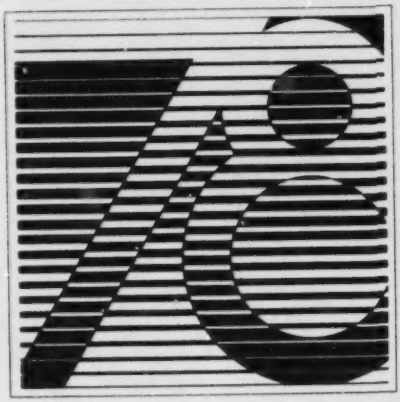
HEALTH PLANNING UNDER WAY

Annual Report Fiscal 1978

Bureau of Health Planning



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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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FOREWORD

This report of the activities of the Bureau of Health Planning has been prepared to provide health planners and other interested persons with a convenient account of the past year's developments and the status of the program. It is intended to be understandable to those who have little or no knowledge of the planning process under The National Health Planning and Resources Development Act, P. L. 93-641, but it will be useful to better informed individuals as well.

The main body of the document is a report of developments at the national level and facts and figures about the program as a whole. Interspersed among the pages of this more formal report are anecdotal accounts of the experiences of individual HSAs. It is hoped that the inclusion of these descriptions will help to dispel the idea that health planning is an abstract process. To those involved in the program, health planning is a vital and necessary effort to constrain health costs and improve the quality and accessibility of health services.

Colin C. Rorrie, Jr., Ph.D.
Director
Bureau of Health Planning

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INTRODUCTION

Fiscal Year 1978 was a year of reorganization for the Bureau of Health Planning and Resources Development (BHPRD). The functions of the Bureau's Division of Facilities Development, along with its personnel, were transferred to a new Bureau of Health Facilities Financing, Compliance and Conversion in the Health Resources Administration. Fiscal 1978 activities for facilities development are contained in a separate report by the new Bureau. BHPRD was renamed the Bureau of Health Planning and continues to administer the health planning program under Title XV of the National Health Planning and Resources Development Act, P. L. 93-641.

In January 1979, Colin C. Rorrie, Jr. was confirmed by the Civil Service Commission as Director for the Bureau of Health Planning. Dr. Rorrie had been Acting Director since the resignation of Harry P. Cain II in April.

AREAWIDE PLANNING

Much of the past three years has been spent in helping establish the network of planning agencies which carry the principal responsibility for health planning and development under P. L. 93-641. Health planning was established in 213 geographic regions, including 205 health service areas served by Health Systems Agencies (HSAs) and eight States, territories and the District of Columbia, which under Section 1536 of the Act, are exempt from designating health service areas and hence eligible for combined grants for both areawide and State planning.

The $107 million allocated by BHP for support of HSAs during FY 78 provided an average per capita funding of 44 cents, up from 41 cents per capita in FY 77. The Continuing Resolution, under which the program will operate through FY 1979 or until passage of a new law, provides for funding at the FY 78 level: the President's budget request for 1980 would increase the funding to $115.4 million or 47 cents per capita.

By November 1978, 168 HSAs had achieved full designation status. Thus, over three-fourths of all HSAs now have developed initial Health Systems Plans (HSPs) and Annual Implementation Plans (AIPs) which meet minimum Federal expectations and have demonstrated a capacity to perform all functions required of them under the statute.

The Department has granted waivers to 29 HSAs, extending their conditional designation up to 12 months. Two HSAs had their designation withdrawn by HEW, the ones in Los Angeles and Puerto Rico. The Los Angeles agency was not renewed because it failed to make adequate progress in development of a health plan for the area, because its governing board membership did not meet the requirements of the health planning Act, and because various management problems identified earlier in the year by the Department had not been corrected. Applications for a replacement agency for Los Angeles must be submitted to the Regional Office by May 15. The Puerto Rico agency also was not performing adequately. The State is hoping for enactment of legislation by Congress to designate it as a 1536 State.

The Health Systems Plan is the HSA's statement of long-range goals for improving the health status of area residents and the health systems serving that population, objectives to be accomplished during the plan period, and long-range actions and

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Planning in Practice—Seattle, Washington

A merger of three hospitals in downtown Seattle will eliminate 160 excess beds and reduce the community's medical costs by about $1.5 million a year.

Staff of the Puget Sound Health Systems Agency participated in the negotiations which led to the merger under which Doctors Hospital and Seattle General Hospital, which have a combined total of 310 beds, will merge with Swedish Hospital Medical Center, a 450-bed referral center, and a new 148-bed, $18.7 million pavillion will be constructed on the Swedish Hospital grounds. The new facility will house an ambulatory care center, an emergency department and the family residency program of Doctors Hospital. It also will provide five intensive care, seven coronary care and 136 medical-surgical beds. Obstetrical services already had been merged in Swedish Hospital.

The predecessor of the Puget Sound Health Systems Agency had recommended a hospital merger in downtown Seattle in 1973, and a later plan specifically recommended that Doctors and Seattle General merge with Swedish. In the fall of 1977, four years of studies and negotiations came to a successful conclusion when the HSA approved the merger.

resources required to achieve the objectives. Its purpose is to establish objectives which, when achieved, will promote a healthful environment and provide for the availability and accessibility of high quality health services in a manner which fosters continuity of care at reasonable cost for all residents of the area.

The Annual Implementation Plan expresses the community's one year objectives for accomplishing the long-range goals set forth in the HSP, as well as the actions needed to achieve these objectives, their resource requirements, and the identification of organizations or agencies responsible for implementing such actions.

The plan must be specific enough for implementation purposes and for supporting the recommendations and decisions emanating from Certificate of Need, Section 1122, appropriateness review functions, and review and approval or disapproval of proposed uses of certain Federal funds.

The December 1976 Guidelines for HSAs to use in developing HSPs and AIPs were revised and new draft Guidelines were issued in June 1978. The revised guidance clarifies ambiguous areas in the initial plan development guidance and lays out the next step in the orderly assumption of the entire range of planning activities. The plans will focus on the National Priorities described in the health planning law and the nine national resource standards contained

Planning in Practice—Greensboro, North Carolina

When the Piedmont Health Systems Agency developed a Health Systems Plan for its area of North Carolina, access to medical care was identified as one of the area's major problems. Accordingly, the annual implementation plan established as one of its goals an increase in the physician/population ratio in the area.

However, when the HSA held a series of public meetings to discuss the plan, the residents of the area told them that transportation, not the lack of physicians, was the major problem.

Now that the Annual Implementation Plan has been altered to reflect local concerns, another set of public meetings will be held to discuss the new implementation plan.

"Our problem," said Ned Clark, executive director of the Piedmont HSA, "was that we relied too much on physician/population ratios. That data did not indicate the specific areas where physicians were needed and those where transportation was needed. We are going back to the communities because the Annual Implementation Plan is supposed to be their work plan. We are obligated to ask them if our AIP reflects what they want us to do."

in the National Guidelines for Health Planning published March 28, 1978, as well as on emergency medical services, mental health services, acute care, and long-term care.

Amendments to Final Regulations governing the designation and funding of HSAs removed previous restrictions limiting the membership of public officials on the Governing Bodies and brought the regulations into conformance with current statutes and court ruling. The regulations previously limited the proportion of the HSA Governing Body which could consist of "public elected officials...representatives of government authorities...and representatives of public agencies in the area concerned with health..." to one-third of the total membership of the body. However, a U.S. District Court ruled that the limitation was not supported by the legislative history of the law.

Further changes in Federal regulations have been proposed to clarify requirements for the composition of Governing Bodies of HSAs and the method of selecting members. The proposed rules identify several groups whose representation must "roughly approximate" each group's percentage of the entire population of the area. The proposed rules suggest several methods for selection of members of HSA Governing Bodies that will allow flexibility in accommodating local needs and circumstances while still assuring that the members are accountable to groups which they presumably represent. Final regulations will be issued in calendar year 1979.

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STATEWIDE PLANNING

There are now 57 State Health Planning and Development Agencies (SHPDAs). During the year, a new one was conditionally designated for the Northern Marianas which had been separated from the Trust Territory of the Pacific Islands.

Appropriations for the State Agencies increased from $24.5 million in FY 1977 to $29.5 million in FY 1978. The President's 1980 budget request for the Agencies is $30 million. Individual grants ranged from a low of $49,772 (in the territories) to a high of $2.6 million. Regulations require that territories receive no less than one half of one percent of the funds available and that other agencies receive no less than one fourth percent of the available funds.

By December 1978, eight State agencies were fully designated—Arkansas, Colorado, Hawaii, Kansas, Maryland, North Dakota, Virginia, and Wyoming. As required for full designation, each of these States has adopted a certificate of need program satisfactory to the Secretary. This program provides for the review of proposals for new construction, replacement and modernization of health facilities and elimination of duplicative health services.

In accordance with the Act, Statewide Health Coordinating Councils (SHCCs) also have been established in 51 States - 10 in FY 1978.

Final regulations for the designation and funding of SHPDAs and SHCCs were issued March 10, 1978.

The State agency is required to develop a preliminary State Health Plan which must be reviewed and modified as necessary, and established by the SHCC as the State Health Plan. The State Health Plan shall be made up of the Health Systems Plans of the HSAs within the State. SHPDAs will be able to perform more effectively with a SHP since many of their mandated functions are interrelated with recommendations contained in the SHP

Final guidelines for developing State Health Plans (SHPs) were issued in August and reflect comments regarding the draft guidelines distributed July 1977. The SHP Guidelines recommended that SHPs established after June 30, 1979 be consistent with the National Guidelines for Health Planning published March 28, 1978.

Planning in Practice—Davenport, Iowa

Under a nine-point agreement between Mercy and St. Luke's Hospitals in Davenport, Iowa, there will be a 9.4 percent reduction in hospital beds, and the two hospitals will establish a Health Services Coordinating Committee to review future construction and planning for both facilities with an eye to avoiding unnecessary duplication.

The two hospitals agreed that cardiac care will be centered in St. Luke's Hospital, neurological services will be at Mercy Hospital, and both will continue to provide basic pediatric and emergency services. St. Luke's, however, will provide more elaborate pediatric services.

The agreement was developed by the Iowa State commissioner of health as a condition of receiving approval from the Illowa Health Systems Agency for $65 million of new construction and renovation. Mercy Hospital will spend $35.4 million to replace its obsolete facility. St. Luke's will spend $29.3 million renovating and expanding its current facility.

In 1973, Mercy submitted an application for renovation. It was denied because it did not reflect cooperation with the other hospital. The recommendation was concurred with at the State level and the application was disapproved.

For the next four years, Mercy and St. Luke's, supported by the local medical society and the planning agency, tried to find ways for the two institutions to begin cooperation. During this time, a consultant's study sponsored by the planning agency recommended the two hospitals consolidate, and the respective boards spent six months trying to work out a merger.

In December 1977, the effort was disbanded and each hospital began to go its own way. Mercy submitted an application to the HSA first, but the HSA board deferred action for 30 days and suggested several areas of joint concern which it urged the hospitals to continue exploring. Meanwhile, the Iowa State health commissioner developed the nine-point agreement, and after meetings with the two hospital boards and the executive director of the Illowa HSA, the two hospitals accepted it.

The Illowa HSA is one of fourteen interstate health planning agencies. It serves the five-county Quad City area in Illinois and Iowa which includes Moline and Rock Island, Illinois, as well as Davenport, Iowa.

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REGULATORY ACTIVITIES

The major regulatory activities to be undertaken by planning agencies are certificate of need (CON) reviews, reviews under Section 1122 of the Social Security Act, and, after the issuance of final regulations, review of the "appropriateness" of existing institutional health services, and review and approval or disapproval of certain proposed uses of Federal health funds. In addition, a number of States are operating rate regulation programs.

The certificate of need programs that States are expected to establish under P. L. 93-641 will replace similar but often less comprehensive programs now in effect in many States and will supplement the capital expenditures review program under Section 1122 of the Social Security Act.

As of October 1978, 40 States had some kind of CON program (though not necessarily satisfactory to the Secretary) and 33 States were participating in the Section 1122 programs. The number of States implementing some form of rate review or regulation is growing, with more than 10 States operating statewide programs. Currently, the major obstacles to success in containing costs appear to be: (1) lack of reliable, valid criteria to be applied to regulatory decisions; (2) absence of good plans, both institutional and community; (3) absence of a comprehensive, sound data base; and (4) lack of meaningful operational linkages among planning and regulatory activities.

On May 16, 1978 proposed regulations governing local and State review of the appropriateness of existing institutional health services were issued. These reviews must be conducted within three years after an HSA is fully designated by DHEW, and every five years thereafter. The HSA's findings are submitted to the SHPDA, which must review all institutional health services in the State and, after considering the recommendations of local planning agencies, make public its findings on the appropriateness of the services. Final regulations on appropriateness review are expected in early 1979.

Proposed regulations were issued on May 9, 1978 for HSA review and approval or disapproval of certain proposed uses of Federal health funds under the Public Health Service Act, the Community Mental Health Centers Act, Comprehensive Alcohol Abuse and Alcoholism Prevention,

Planning in Practice—Bismarck, North Dakota

How does an HSA with a staff of five and a limited budget make itself known throughout a 45,000 square mile area? The Western North Dakota Health Systems Agency, which faced this problem, decided to hold three one-day regional conferences. The first was on rural health care initiatives, the second on health maintenance organizations, and the third on the State certificate of need law.

In addition to making the agency more visible, the conferences were to educate both board members and local communities about key health care issues. However, the conferences have had a more direct impact on some of the communities in the HSA. After the first conference, three communities submitted applications for doctors to the National Health Service Corps. Two physicians already are working in one of the communities. A fourth community has contracted with a group practice in a larger community to provide satellite care.

The health maintenance organization conference was organized to discuss many of the negative comments that were being made about HMOs. Since the pros and cons of HMOs were presented, two communities applied for, and received, Federal money to conduct a feasibility study, and one more has submitted an application.

A fourth conference, which will focus on long-term institutional planning, is being scheduled. "The conferences have become more than just a way to get the most out of our dollars," said Barry Halm, executive director of the HSA. "They have become ways to get communities to think about their problems and take some approaches which they had not considered before."

Treatment and Rehabilitation Act, and the Drug Abuse Office and Treatment Act. The purpose of these reviews is to ensure that, to the greatest extent practicable, Federal health funds will be spent in a manner consistent with and supportive of State and local health plans. Final regulations are expected in early 1979. In addition, the Research and Training section of the review and approval regulations will be issued as a separate Notice of Proposed Rulemaking.

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TECHNICAL ASSISTANCE

National Health Planning Information Center

The National Health Planning Information Center serves as the Bureau focal point for the collection and dissemination of health planning information. During Fiscal Year 1978 approximately 4,500 documents were added to the data base, so there are now over 20,000 references on the searchable computer files. The Center responded to over 3,600 reference requests by search of the data base, preparation of an annotated bibliography, and/or provision of published documents. Thirty five health planning documents have been published by the Center and 46 are in process. Among the publications completed during FY 78 are two guides on data collection and use, the compilation of Bureau Program Information Letters and Program Policy Notices for FY 77, and bibliographies on Women and the Health System, Community Nutrition, and the Certificate of Need Program. Approximately 100,000 copies of publications were distributed during Fiscal 1978.

A Policy Information Hotline is being field tested by the Bureau in response to recommendations from the National Council on Health Planning and Development. The Hotline provides toll-free telephone access to planners for questions about health planning policy. Center staff assigned to the Hotline processed over 75 inquiries from October 1 to December 31. The field test began October 1 in Region X and November 1 in Region I and continued until mid-March 1979, when it was to be evaluated for possible Hotline expansion to all Regions.

In order to acquire the health planning literature from other countries, the Center has established bilateral agreements with several information centers in Europe. Through HECLINET (Health Care Literature Information Network) the Center exchanges information with the German, Swiss, and Danish Hospital Institutes. An exchange with England is being developed, as is an exchange with the Biblioteca Regional de Medicina (BIREME) for the health planning information from all of Central and South America.

Centers for Health Planning

The 10 Centers for Health Planning, under contract with the Bureau, continued to provide technical assistance to staff and Governing Body members of planning agencies.

NATIONAL GUIDELINES

On March 28 1978, the Department issued the first set of National Guidelines for Health Planning as required under the health planning act. The guidelines include standards concerning the supply, distribution and organization of health care resources.

The draft guidelines published in September 1977 generated a great deal of controversy. As a result, the Health Resources Administration sponsored five public meetings in November to discuss the proposed Guidelines. Commenters expressed particular concern that small rural or community hospitals would be forced to close, and that the standards for obstetrical units might be too strict. There also was concern that the proposed Guidelines would take decisionmaking out of local hands. After two revisions, the first set of Guidelines was issued in final form on March 28, 1978.

The major standards encompassed by the Guidelines include:

- A maximum of four hospital beds per 1,000 persons in a health service area.
- An overall average annual occupancy rate of at least 80% for all hospitals combined in a health service area.
- At least a 75% average occupancy rate and at least 1,500 births annually for hospitals that provide care for complicated obstetrical problems.
- No more than four neonatal intensive and intermediate care beds per 1,000 live births.
- A minimum of 20 beds per pediatric unit in urban areas.
- Average annual occupancy rates ranging from 60 to 75% for pediatric units, based on their size.
- At least 200 open heart procedures annually in any institution in which open heart surgery is performed for adults, and at least 100 heart operations annually in any institution in which pediatric open heart surgery is performed.
- At least 300 cardiac catheterizations annually in any adult catheterization unit, and at least 150 cardiac catheterizations annually in any pediatric catheterization unit.

- A service area with a population of at least 105,000 persons or treatment of at least 300 cancer cases annually for megavoltage radiation therapy units.
- At least 2,500 procedures per year for each computed tomographic scanner.
- Plans consistent with already-established HEW standards and procedures for providers of end-stage renal disease services.

HSPs and AIPs established after December 31, 1978 must be consistent with these resource standards, as well as with national health planning goals on health status, health promotion and prevention, and access to health care which are expected to be published soon.

Each HSA is responsible for determining whether standards need adjustment to accomodate special local conditions. The adjustments are to be justified on the basis of thorough analyses, and must be reviewed by the SHPDA in its preparation of the preliminary State Health Plan and by the SHCC in its preparation of the SHP. On the basis of that review, the adjustment may be made part of the State Health Plan.

NATIONAL COUNCIL

The National Council on Health Planning and Development became fully operational in Fiscal 1978, holding 10 meetings during the year.

Among the Council's major activities was participation in the development of the National Guidelines for Health Planning.

The Council also established a special task force to study how to improve the transmission of health planning policy information to health planning participants. As a result of its recommendations, the Health Resources Administration established a "hotline" for HSA members and other health planning participants in Regions I and X. Callers can request clarification of HEW policies and related information.

To facilitate its work, the Council established four subcommittees. Three subcommittees were established to study, in depth, each of the three areas of responsibility of the Council under the statute: guidelines, goals, priorities and standards; implementation and administration of the health planning act; and technology and productivity. The fourth subcommittee is to coordinate agenda planning.

Four Council appointments for six year terms were made by the Secretary in the first planned turnover in membership.

New members are former HEW Assistant Secretary for Health and Scientific Affairs Philip R. Lee, M.D.; chairman of the Adams County (Colorado) Board of County Commissioners Pete M. Mirelez; and President of the Health Insurance Plan for Greater New York Robert L. Biblo. The appointments are for the period August 1, 1978 to July 31, 1984.

Laurence Levinson, Vice President, Gulf and Western, was reappointed. His initial appointment was in December 1977. The terms of Phyllis Landrieu of New Orleans, Dr. Elena Padilla of New York University, and David G. Williamson of the Hospital Corporation of America, Nashville, expired.

PROGRAM POLICY DOCUMENTS

Schedule for Issurance of Regulations

Final Regulations	Date Published
1. Health Systems Agencies (designation and funding)	3/26/76
Funding Amendment	4/6/77
Technical Amendment	1/6/78
2. State Agencies (designation and funding)	3/10/78
3. Certificate of Need	1/21/77
Amendment (bed capacity)	4/8/77
4. National Guidelines for Health Planning	3/28/78

Proposed Regulations (NPRMs*)	Date Published
1. Certificate of Need Review for HMOs (amendment to CON regulations	3/17/78
2. Section 1122 of the Social Security Act (administered by BHP)	3/19/76
3. Review and Approval of Use of Federal Funds	5/9/78
4. Appropriateness Review	5/16/78
5. Governing Body Requirements for Health Systems Agencies	5/26/78

Guidelines (no regulations anticipated)	Date
1. Guidelines Concerning the Development of State Health Plans	8/18/78
2. Guidelines for the Development of Health Systems Plans and Annual Implementation Plans	2/12/79

*Notices of Proposed Rulemaking

THE STATUTE

There were two health planning bills introduced in the Congress in Fiscal 1978. S. 2410 was passed by the Senate on July 27, 1978. H.R. 11488 was reported out by the House Interstate and Foreign Commerce Committee, but the full House failed to act on it before adjournment. New bills are expected to be introduced early in 1979.

Among the changes proposed in the Senate bill was an amendment which provided that the "healthful environment" which HSPs are to describe should deal primarily with

health care equipment and services provided by health care facilities in the area.

Several other amendments contained in that Senate bill are similar to those contained in the House version and are therefore likely to be contained in any final bill. One would clarify the role of the governor and the SHCC in HEW's designation or termination of HSAs and State agencies.

Another Senate amendment called for HSAs to have to explain to HEW, the State agency and the SHCC the reasons for any inconsistencies of the Health Systems Plan with the National Guidelines on Health Planning. Current statute requires that the HSP be "consistent with" the National Guidelines.

The Senate-approved bill would increase membership on the National Council on Health Planning and Development from 15 to 20 members.

Another Senate amendment would prevent planning agencies from "pocket vetoing" an application for review by failing to act within the required time period. Current law provides that such inaction constitutes a negative finding or decision.

Congress was not able to agree on a final bill, and on October 14, 1978, it passed House Joint Resolution 1139, extending the authorization for the health planning program through September 30, 1979, and continuing appropriations at the FY 1978 level.

LOOKING AHEAD

During the year ahead, the Bureau will concentrate on a number of priority activities aimed at moving the health planning program away from the setting-up stage and into a fully operating planning system. Priorities which the Bureau staff and health planning personnel in HEW's Regional Offices will address during Fiscal Year 1979 are:

- Monitor and Assess HSAs and SHPDAs
- Fully Designate SHPDAs and Remaining HSAs
- Assist in Revision and Implementation of plans
- Develop Information Systems
- Help Develop Certificate of Need Programs
- Monitor 1122 Performance in States
- Initiate Review and Approval Function
- Initiate Appropriateness Review

The earliest effort will be directed toward fully designating the remaining 37 HSAs and 49 SHPDAs. The primary focus will be on the 24 HSAs which received a waiver or an extension of time to achieve full designation.

By the end of FY 1979, the Bureau expects that 95 percent of all HSAs (195) will have reached full designation and have acceptable Health Systems Plans. The Bureau expects that all but two or three of the SHPDAs will have reached full designation and the same number of States will have acceptable Certificate of Need programs. In addition, the Bureau expects that all SHCCs will be established and operating and that all States will have prepared their preliminary State Health Plans.

Section 1535 of the Act requires that each fully designated agency be reviewed in detail at least every three years in terms of its structure, operation and performance. During 1979, the Bureau plans to review 25 percent of the HSAs, as well as review the progress of all agencies which have received waivers, and SHPDAs, prior to making a decision with respect to full designation. The Bureau will perform an increased number of detailed assessments in 1980 and 1981 so that all State and local agencies will be assessed during the three year period.

The basis for the assessments are the agency performance standards

which will be completed by August 1979. For HSAs the initial set of standards has been developed and is currently being used to measure agency performance, especially in terms of agency compliance with the law. For SHPDAs, standards covering "optimal" expectations have been issued; compliance standards for these agencies are under development.

The Bureau expects greater coordination of the State programs between CON and 1122 programs. The Bureau also expects to increase its liaison with the Health Care Financing Administration in order to develop specific procedures to help HCFA track the granting or withholding of Medicare and Medicaid and Title V reimbursements under the Section 1122 program, which the planning agencies administer.

Finally, the Bureau will begin to implement an appropriateness review program on a national basis. Both the Review and Approval and the Appropriateness Review final regulations are expected to be promulgated in mid FY 79. SHPDAs and HSAs are not permitted to conduct these review activities prior to final regulations. However, both functions must be initiated within six months after publication of final regulations. By the end of FY 79, 75 to 100 percent of the fully designated agencies are expected to initiate these activities.